DMA-410: 09-TPL

TCN | | | | | | | | | | | | | | | | |

DEPARTMENT OF COMMUNITY HEALTH - DIVISION OF MEDICAL ASSISTANCE
COB NOTIFICATION FORM

Member Name: _____ **Medicaid ID #:** _____

I. CO-PAYMENT NOTIFICATION

No EOB Available. Coverage is through _____
insurance/benefit plan. The co-payment for this service is _____.

II. COB NON-COVERAGE AFFIDAVIT

I submitted my claim(s) to _____ on _____
Insurance Carrier *Date*

for payment. After receiving no response, I contacted the carrier on _____ for confirmation.
Date

Insurance Representative: _____ Telephone #: _____

_____ Insurance was cancelled on _____.
Date

_____ Service is non-covered; annual/lifetime service limits exceeded.

_____ Member not covered under this policy.

_____ Out-of-Network Provider, No In-Network provider available to provide Medicaid covered services (explain below).

_____ Other (explain) _____

_____

By signing, I certify that, to the best of my knowledge, the information above is verified and accurate, and that this notification form applies to any associated claim(s) and is made a part thereof.

_____ _____ _____
Signature of Patient Account Representative ***Date*** ***Provider #***

Note: This statement must be in accordance with the provisions of Part I, Policies and Procedures, Chapter 200 - Timely Submission, Section 202.2(b).

Attach this form to your claim(s) for paper claim submission, or if claim submitted electronically, indicate the associated TCN above and forward to GHP for processing.

III. COB INFORMATION UPDATE

When completing only this portion of the form, it may be faxed to GHP ATTN: COB Unit at 866-483-1044 or 866-483-1045 or mailed to GHP, Attn: COB Unit, PO Box 5000, McRae, GA 31055; If there are multiple cards, e.g., a medical card and a pharmacy card, complete separate forms or make copies of all cards (front & back) to submit with this form.

COB INFORMATION: ***Please complete in full or attach a copy of the insurance card(s), front and back.***

Policyholder: _____ **Pt. Relationship to Policyholder:** _____

Insurance Carrier: _____ **Policy #:** _____

Employer: _____ **Group #:** _____

Subscriber/Member ID #: _____ **Effective Date:** _____

Coverage Type(s): ***(Circle all that apply)*** **HMO/PPO Major Medical Dental Vision Pharmacy Long Term Care**

Other (*Specify*): _____

THIS FORM MAY BE PHOTOCOPIED